STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILI		nstruction 00	(X3) DATE S COMPL		
		155214	B. WING			06/21/2	011
	PROVIDER OR SUPPLIER			203 FRA	DDRESS, CITY, STATE, ZIP CODE ANCISCAN DRIVE I POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
F0000			F00	000	St. Anthony Home ("the prov submits this Plan of Correction ("POC") in accordance with specific regulatory requirement it shall not be construed as a admission of any alleged deficiency cited. The Provides submits this POC with the intention that it be inadmission any third party in any civil or criminal action against the Provider or any employee, ago officer, director, or sharehold the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve basis, in any way, for the selection and / or imposition future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Serv ("CMS"), the state of Indiana any other entity; or (2) to sen any way, to facilitate or promaction by any third party again the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measure as that concept is employed Rule 407 of the Federal Rule Evidence and should be inadmissible in any proceeding that basis.	ents.  n er ele by gent, er of ices or e, in ote nst o	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HTE312

Facility ID:

000120

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155214		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  06/21/2011		
	(EACH DEFICIEN		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ANCISCAN DRIVE N POINT, IN46307  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	1	(X5) COMPLETION DATE
	(PSR) to the Rec Licensure Survey Survey dates: Jun Facility number: Provider number AIM number: Survey team: Regina Sanders, Kelly Sizemore, Census bed type: SNF: 23 NF: 108 SNF/NF: 30 NCC: 12 Total: 173 Census Payor typ Medicare: 24 Medicaid: 101 Other: 48 Total: 173 Sample: 15 These Deficience findings cited in 16.2.	: 155214 100274780 RN, TC RN	F0	000	St. Anthony Home ("the prosubmits this Plan of Correct ("POC") in accordance with specific regulatory requirem It shall not be construed as admission of any alleged deficiency cited. The Provides submits this POC with the intention that it be inadmissionly third party in any civil of criminal action against the Provider or any employee, a officer, director, or sharehold the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Prodetermines that the disputer findings: (1) are relied upon adversely influence or serve basis, in any way, for the selection and / or imposition future remedies, or for any increase in future remedies are imposed by the Centers for Medicare and Medicaid Ser ("CMS"), the state of Indianal any other entity; or (2) to se any way, to facilitate or proraction by any third party again the Provider. Any changes Provider policy or procedure should be considered to be subsequent remedial measures as that concept is employed Rule 407 of the Federal Rule Evidence and should be inadmissible in any proceed that basis.	ents. an  der  ble by  agent, der of  sovider  to eas a  of  vices a or rve, in note ainst to es  ures l in es of	

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  155214	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMPLETED - 06/21/2011	
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE ANCISCAN DRIVE N POINT, IN46307	<u>. I</u>	
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F0282 SS=E	facility must be pro	ded or arranged by the ovided by qualified persons a each resident's written	F0282	F282 1.1 Regarding resident #1 Unit Nurse Manager / desig immediately assessed resid 6/20/11 with no adverse rea noted. Licensed staff notific physician and family of the occurrence on 6/20/11. 1.2 Unit Nurse Managers designees completed round 6/20/11 for all residents curr on oxygen to ensure the flor was accurate with no other deficiencies noted. Unit Nu Managers / designees completed rounds on 6/20/11 for all residents currently receiving Enteral feedings to ensure proper infusion times were followed no other deficiencies noted.	Innee Ident on Identions I	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	155214	A. BUII	LDING	00	COMPLETED 06/21/2011
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					1.3 A directed inservice will held for licensed staff regard	
					following physician orders re	- 1
					to proper administration of	
					oxygen by 7/15/11. Licensed	d staff
					orientation program will be	
					updated to reflect inservice	
					content to ensure ongoing sustainable compliance. To	
					monitor staff compliance with	1
					directed inservice training (ar	
					allow management to	
					immediately address potentia	al
					noncompliance), Unit Nurse	
					Managers / designees will complete rounds twice weekl	ly of
					five (5) residents per unit on	•
					shifts who require oxygen for	
					(6) months to ensure physicia	
					orders are being followed and	
					flow rate is accurate beginning the week of 7/4/11. A directed	• 1
					inservice will be held for licer	
					staff regarding following phys	
					orders related to proper	
					administration of Enteral feed	dings
					by 7/15/11. Licensed staff	
					orientation program will be updated to reflect inservice	
					content to ensure ongoing	
					sustainable compliance. To	
					monitor staff compliance with	
					directed inservice training (ar	nd to
					allow management to immediately address potentia	,
					noncompliance), Dietitian /	<sup>21</sup>
					designee will complete round	ls
					twice weekly of five (5) reside	
					per unit on all shifts who requ	uire
					Enteral feedings for six (6)	
					months to ensure proper infu times are being followed	sion
					unles are being followed	

NAME OF PROVIDER OR SUPPLIER STANTHONY HOME  STREET ADDRESS. CITY, STATE ZIPCODE 202 FRANCISCAN DRIVE CROWN POINT, IN46307  ICACH DEFICIENCY MIST BE PERCEDED BY FULL TAG  REGILATORY OR LSC IDENTIFYING INFORMATION)  TAG  REGILATORY OR LSC IDENTIFYING INFORMATION)  TAG  REGILATORY OR LSC IDENTIFYING INFORMATION)  TAG  Deginning the week of 774/11. 1.4 The DON / designee will report audit findings to the Continuous Quality Improvement (CQI) Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 7715/11. 2.1 Regarding resident #135, Unit Nurse Manager / designee immediately assessed resident on 6/2011 with no adverse reactions noted. Licensed nurse notified physician and family of the occurrence on 6/2011. 2.2 Unit Nurse Managers / designee serviewed current physician orders and MARs of residents receiving weekly blood pressures by 7715/11. 2.2 Unit Nurse Managers / designee reviewed current physician orders and MARs of residents receiving weekly blood pressures by 7715/11. Licensed staff orientation program will be updated to reflect inservice will be held for licensed staff regarding following physician orders related to obtaining weekly blood pressures by 7715/11. Licensed staff orientation program will be updated to reflect inservice content to ensure ongoing sustainable complaince. To monitor staff orientation program will be updated to reflect inservice content to ensure ongoing austainable complaince. To monitor staff orientation program will be updated to reflect inservice content to ensure ongoing austainable complaince. To immediately address potential anoncompliance, Unit Nurse	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CON	NSTRUCTION 00	(X3) DATE : COMPL		
NAME OF PROVIDER OR SUPPLIER  ST ANTHONY HOME  (XA) ID PREFIX (BACH DETICIENCY MUST BE PERCEDED BY PULL TAG REGULATORY OR I.S.C IDENTIFYING INFORMATION)  REGULATORY OR I.S.C IDENTIFYING INFORMATION)  PREFIX (BACH DETICIENCY MUST BE PERCEDED BY PULL TAG REGULATORY OR I.S.C IDENTIFYING INFORMATION)  PREFIX (BACH DETICIENCY MUST BE PERCEDED BY PULL TAG REGULATORY OR I.S.C IDENTIFYING INFORMATION)  Despining the week of 7/4/11.  1.4 The DON / designee will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months. The QQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance.  1.5 Systemic changes will be completed by 7/15/11.  2.1 Regarding resident #135, Unit Nurse Manager / designee immediately assessed resident on 6/20/11 with no adverse reactions noted. Licensed nurse notified physician and family of the occurrence on 6/20/11.  2.2 Unit Nurse Manager / designee immediately assessed resident on 6/20/11 to ensure physician orders and MARs of residents receiving weekly blood pressures to 19/20/11 to ensure physician orders followed with no other deficiencies noted.  2.3 A directed inservice will be held for licensed staff regarding following physician anders related to obtaining weekly blood pressures by 7/15/11. Licensed staff orientation program will be updated to reflect inservice unit by monthly substantable compliance. To monitor staff compliance with directed inservice training (and to allow management to immediately address potential noncompliance). Unit Nurse	AND TEAN	or connection				<del></del>	l	
NAME OF PROVIDER OR SUPPLIER  STANTHONY HOME  PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  BURGULATORY OR LSC IDENTIFYING INFORMATION)  Deginning the week of 74/411.  1.4 The DON / designee will report audit findings to the Continuous Quality Improvement (CQI) Committee on will monitor data presented for any trends, and determine if further monitoring is necessary for compilance.  1.5 Systemic changes will be compiled by 7/15/11.  2.1 Regarding resident #135, Unit Nurse Manager / designee immediately assessed resident on 6/20/11 with no adverse reactions noted. Licensed nurse notified physician and family of the occurrence on 6/20/11.  2.2 Unit Nurse Managers / designees reviewed current physician orders and MARS of residents noted. Survey of the occurrence on 6/20/11.  2.3 A directed inservice will be held for licensed staff regarding following physician orders related to obtaining weekly blood pressures on 6/20/11 to ensure physician orders related to obtaining weekly blood pressures by 7/15/11. Licensed staff orientation program will be updated to reflect inservice will be held for licensed staff regarding following physician orders related to obtaining weekly blood pressures by 7/15/11. Licensed staff compliance. To monitor staff compliance. To monitor staff compliance to immediately address potential noncompilance). Unit Nurse						DDRESS CITY STATE 7IP CODE		
CROWN POINT, IN46307   CROWN POINT, IN46307	NAME OF I	PROVIDER OR SUPPLIER						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)    REGULATORY OR LSC IDENTIFYING INFORMATION)   REGESS.REFERENCE TO TAKE APPROPRIATE INFORMATION	ST ANTH	IONY HOME						
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG Beginning the week of 774/11.  1.4 The DON / designee will report audit findings to the Continuous Quality Improvement (CQI) Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance.  1.5 Systemic changes will be completed by 71/5/11.  2.1 Regarding resident #135, Unit Nurse Manager / designee immediately assessed resident on 6/20/11 with no adverse reactions noted. Licensed nurse notified physician and family of the occurrence on 6/20/11.  2.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving weekly blood pressures on 6/20/11 to ensure physician orders followed with no other deficiencies noted.  2.3 A directed inservice will be held for licensed staff regarding following physician orders related to obtaining weekly blood pressures by 7/15/11. Licensed staff orientation program will be updated to reflect inservice inservice content to ensure ongoing sustainable compliance. To monitor staff compliance. To monitor staff compliance. To monitor staff compliance. To monitor staff compliance with directed inservice training dand to allow management to immediately address potential noncompliance). Unit Nurse	1 ' '					PROVIDER'S PLAN OF CORRECTION		
beginning the week of 7/4/11.  1.4 The DON / designee will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance.  1.5 Systemic changes will be completed by 7/15/11.  2.1 Regarding resident #135, Unit Nurse Manager / designee immediately assessed resident on 6/20/11 with no adverse reactions noted. Licensed nurse notified physician and family of the occurrence on 6/20/11.  2.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving weekly blood pressures on 6/20/11 to ensure physician orders and MARs of residents receiving weekly blood pressures on 6/20/11 to ensure physician orders followed with no other deficiencies noted.  2.3 A directed inservice will be held for licensed staff or		`		P		CROSS-REFERENCED TO THE APPROPRIAT	ΓE	
I I I I I I I I I I I I I I I I I I I		`				beginning the week of 7/4/11  1.4 The DON / designee w report audit findings to the Continuous Quality Improver (CQI) Committee monthly for (6) months. The CQI Commitwill monitor data presented for any trends, and determine if further monitoring is necessar for compliance.  1.5 Systemic changes will be completed by 7/15/11.  2.1 Regarding resident #135 Unit Nurse Manager / design immediately assessed reside 6/20/11 with no adverse reach noted. Licensed nurse notific physician and family of the occurrence on 6/20/11.  2.2 Unit Nurse Managers / designees reviewed current physician orders and MARs or residents receiving weekly blood pressures on 6/20/11 to ensurphysician orders followed with other deficiencies noted.  2.3 A directed inservice will held for licensed staff regardifollowing physician orders reto obtaining weekly blood pressures by 7/15/11. Licens staff orientation program will updated to reflect inservice content to ensure ongoing sustainable compliance. To monitor staff compliance with directed inservice training (an allow management to immediately address potential committed inservice training (an allow management to immediately address potential committed inservice training (an allow management to immediately address potential committed inservice training (an allow management to immediately address potential committed inservice training (an allow management to immediately address potential committed inservice training (an allow management to immediately address potential committed inservice provides and committed inservice inservice committed inservice provides and committed inservice training (an allow management to immediately address potential committed inservice provides and committed inservice inservice committed inservice provides and committed inservice inservice committed inservice provides and committed inservice inservice committed inservice inservice committed inservice inservice committed inservice inservice inservice committed inservice inservice inservice inservice inservice inservic	ill ment r six ittee or ary be see ent on ctions ed of ood ure ch no be ing lated sed be	

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				complete audits twice weekly five (5) residents per unit who require weekly blood pressur for six (6) months to ensure physician orders are being followed (reviewing current physician orders and MARs accuracy / completion) begind the week of 7/4/11.  2.4 See 1.4 above.  2.5 See 1.5 above.  3.1 Regarding resident #148 Unit Nurse Manager / design immediately assessed reside 6/20/11 with no adverse reach noted. Licensed staff notified physician and family of the occurrence on 6/20/11.  3.2 Unit Nurse Managers / designees reviewed current physician orders, MARs and TARs of resident receiving endrops on 6/20/11 to ensure physician orders followed with other deficiencies noted. AD notified pharmacy to ensure medications will be document on the MAR rather than TAR 6/20/11.  3.3 A directed inservice will held for licensed staff regard following physician orders reto eye drop administration by 7/15/11. Licensed staff orientation program will be updated to reflect inservice content to ensure ongoing sustainable compliance. To monitor staff compliance with directed inservice training (an allow management to	for ning  5, eee ent on etions d  the no eooN all eted on be ing lated  7

	T OF DEFICIENCIES  DF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	A. BUILDING B. WING	00	COMPLETED 06/21/2011
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				immediately address potent noncompliance), ADON / designee will review five (5) resident physician order she MARs and TARs with eye did twice weekly per unit for six months to ensure physician orders are being followed (reviewing for accuracy / completion) beginning the word for followed.  3.4 See 1.4 above.  3.5 See 1.5 above.  4.1 Regarding resident #33 licensed staff immediately assessed resident on 6/20/100 no adverse reactions noted. Licensed staff notified physician damily of the occurrence 6/20/11.  4.2 Unit Nurse Managers / designees reviewed current physician orders and diabet sheets of residents receiving blood glucose monitoring are insulin administration on 6/2 to ensure physician orders followed with no other deficiencies noted.  4.3 A directed inservice will held for licensed staff regard following physician orders following sustainable compliance to blood glucose monitoring insulin administration by 7/1 Licensed staff orientation program will be updated to a inservice content to ensure ongoing sustainable compliance directed inservice training (a allow management to	eets, rops (6)  veek  11 with cian e on  ic flow grad and 5/11.  reflect cance. with

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 06/21/2	LETED
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				immediately address pote noncompliance), Unit Nur Managers / designees wil five (5) resident POS and flow sheets per unit of the receive blood glucose me and insulin administration weekly for six (6) months ensure physician orders a followed (reviewing for accompletion) beginning the of 7/4/11.  4.4 See 1.4 above. 4.5 See 1.5 above.  5.1 Regarding resident # licensed staff immediately assessed resident on 6/2 no adverse reactions note Licensed staff notified phy and family of the occurrer 6/20/11.  5.2 Unit Nurse Managers designees reviewed curre physician orders and MAI residents receiving antipla medication on 6/20/11 to physician orders followed other deficiencies noted.  5.3 A directed inservice wheld for licensed staff reg following physician orders to antiplatelet medication administration by 7/15/11 Licensed staff orientation program will be updated to inservice content to ensure ongoing sustainable company to monitor staff compliant directed inservice training allow management to immediately address pote	se I review diabetic se who nitoring twice to ire being curacy / e week  24, // 0/11 with ed. //sician ince on si / ent Rs of atelet ensure with no will be arding s related  oreflect re colliance. ce with (and to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155214		(X2) MULTIPLE  A. BUILDING  B. WING	00	ľ	E SURVEY PLETED (2011	
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IAU	Based on observatinterview, the fact physicians' order followed, related times, a blood profor 5 of 15 reside physicians' order sample of 15. (R #145, and #167)  Findings include  1. During an observation of the ding was infured to the desired was in the feeding was infured to the desired was being canula at 7 liters.  During an observation of the desired was a feeding was being canula at 7 liters.  During an observation of the desired was a feeding was being canula at 7 liters.  During an observation of the desired was a feeding was being canula at 7 liters.	ation, record review, and callity failed to ensure s and care plans were to, oxygen, tube feeding essure, and medications, ents reviewed for s and care plans in a esidents #24, #33, #135,  :  servation of Resident 1 at 8:30 a.m., the er room and the tube sing at 60 cc (cubic four and the resident's g administered by nasal	IAU	noncompliance), Unit Managers / designees complete audits twice five (5) residents per under the six (6) months to ensure physician order follow (reviewing for accurate completion) beginning of 7/4/11.  5.4 See 1.4 above.  5.5 See 1.5 above.	s will weekly of unit who edication for ure ed	DATE

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
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		nager indicated the					
	resident's tube feeding was still infusing at						
	60 cc an hour and	d she indicated the					
	resident's oxygen was set at 8 liters per minute.						
	Resident #167's 1	record was reviewed on					
	06/20/11 at 8:35 a.m. The resident's						
	diagnoses included, but were not limited						
	to respiratory failure and hypertension.						
		d 06/16/11, indicated the					
	resident had a tul	be feeding present. The					
	interventions inc	luded, "Provide feeding					
	via pump per MI	O orders"					
	A care plan date	d 06/16/11, indicated the					
		supplemental oxygen.					
	1 ^	s included, "O2					
	(oxygen) per md	(sic) orders					
	1 * *	ler, dated 06/16/11,					
	indicated the resi	ident's tube feeding was					
	to be increased o	n 06/18/11 to 60 cc's an					
	hour for 16 hours	s, on at 3 p.m. and off at					
	7 a.m.	-					
	The resident's me	edication record, dated					
		the tube feeding was					
		_					
	started on 06/19/	11 at 3 p.111.					
	<b>.</b>	1 1 1 1 0 6 11 0 11 1					
		ler, dated 06/19/11					
	indicated an orde	er for oxygen at 10 liters					
	per minute.						

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	
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TAG	2. Resident #135 on 06/20/11 at 11 diagnoses include to, hypertension at the Physician's Edated 06/11, indicated 06/11, indicated 06/11, indicated 06/11, indicated 06/11, indicated the resident was a lack indicate the resident been monitored of (Fridays).  A Nurses' Note, of p.m., indicated the pressure was 116 dated 06/10/11 the a.m., lacked docuresident's blood promitored as ord physician.  During an intervial. During an intervial. During an intervial.	S's record was reviewed a.m. The resident's ed, but were not limited and gout.  Recapitulation Orders, cated an order to monitor od pressure weekly on  Administration Record, cated the resident's blood in monitored on 06/03/11. of documentation to ent's blood pressure had on 06/10/11 and 06/17/11  Idated 06/13/11 at 6:01 he resident's blood /74. The Nurses' Notes arough 06/20/11 at 4:18 himentation to indicate the pressure had been ered by the resident's  Seew on 06/20/11 at 11:15 hicated she did not find of indicate the resident's and been monitored as		TAG			DATE

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	3. Resident #145's record was reviewed on 06/20/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus.						
	dated 06/11, indiartificial tears, a	Recapitulation orders, cated an order for dminister two drops into imes daily. The order n 03/25/11.					
	06/11, indicated been administere a yellow highlight order and no init	eatment record, dated the medication had not ed as ordered. There was need line through the ials were on the treatment the the eye drops had been					
	(MAR), dated 06 documentation to tears had been and the physician and	Administration Record 5/11, lacked o indicate the artificial dministered as ordered by d lacked documentation an order for the artificial					
	06/20/11, lacked	orders, from 03/25/11 to documentation to icial tears had been					
	I -	iew on 06/20/11 at 10:55 Manager #1 indicated she					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	OF CORRECTION	155214	- 1	LDING	00	06/21/2	
		133214	B. WIN			00/21/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  ANCISCAN DRIVE		
ST ANTH	IONY HOME			1	N POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		here the artificial tears					
		stered as ordered by the					
		ndicated there had not					
	been a discontinuation order written for						
	the artificial tears.						
		s record was reviewed on					
		a.m. Resident #33's					
		ed, but were not limited					
		dent diabetes mellitus,					
	hypertension, and dementia.						
		capitulation Orders,					
		an original date of					
	1/21/11, indicate	_					
	_	and record 2 times daily					
	-	m. and an order for					
		R per sliding scale					
		sed on blood sugar					
	results): sub-Q (	subcutaneous):					
l	60-150= 0 units						
	151-200= 2 units						
	201-250 = 4  units						
	251-300=6 units						
	301-350=8  units						
	351-400= 10 unit						
	> (over) 400= 12						
	< (less than) 60 c						
	(						
	A Diabetes Care	Plan, dated 11/8/10 and					
	updated 5/11, ind	licated "Accuchecks as					
	ordered. Admini	ister insulin per sliding					
	scale"						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE S	ETED
		155214	B. WIN	G		06/21/2	011
	PROVIDER OR SUPPLIER		-	203 FR	ADDRESS, CITY, STATE, ZIP CODE ANCISCAN DRIVE N POINT, IN46307		
					N FOINT, IN40307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
PREFIX	REGULATORY OR  A Diabetic Flow indicated on 6/16 blood sugar was given.  During an intervit 6/20/11 at 2:05 p of insulin should  5. Resident #24's 6/20/11 at 8:55 a diagnoses include to, congestive her knee amputation,  A Physician's Red 06/11 with an ori indicated Anagre medication) 0.5 mouth daily, hold N/P (Nurse Pract  Lab results for plindicated a result 130-400). At the indicated to "rest  A Medication Ad (MAR), dated 06 Anagrelide HCL by mouth daily, I notify N/P (Nurse Pract)	Sheet, dated 06/2011, at 4 p.m. the resident's 161 and no insulin was 164 with LPN #6, on .m., she indicated 2 units have been given.  Seed, but were not limited art failure, left above and atrial fibrillation.  Capitulation Order, dated ginal date of 9/10/09, lide HCL (antiplatelet milligrams 1 capsule by dif platelets <250 notify itioner).  Attention of the lab it was art agrelide (sic)."  Imministration Record /2011, indicated 0.5 milligrams 1 capsule nold if platelets <250 e Practitioner). The dates		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		nitialed and circled, the medication had not					

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l	OF CORRECTION	IDENTIFICATION NUMBER:  155214	ľ	LDING	00 	COMPI 06/21/2	LETED
	PROVIDER OR SUPPLIER		<u> </u>	STREET A	ANCISCAN DRIVE N POINT, IN46307	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	been given.  During an interv 6/20/11 at 10:35 medication was a strip. The order pharmacy did no given.  This Federal tag The facility faile	iew with LPN #6, on a.m., she indicated the not in the medication was not written so t send it, so it was not  was cited on 05/02/11. d to implement a correction to prevent					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	7
AND PLAN	OF CORRECTION	155214	A. BUILDING	00	06/21/2011	
		100214	B. WING	DDRESS, CITY, STATE, ZIP CODE	00/21/2011	
NAME OF F	PROVIDER OR SUPPLIER		l	ANCISCAN DRIVE		
ST ANTH	IONY HOME			N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	PLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DA	ATE
F0441 SS=D	Infection Control P a safe, sanitary an and to help prever transmission of dis  (a) Infection Control The facility must e Program under wh (1) Investigates, co infections in the fa (2) Decides what p isolation, should be resident; and (3) Maintains a rec corrective actions  (b) Preventing Spr (1) When the Infect determines that a prevent the spread must isolate the re (2) The facility must	stablish an Infection Control nich it - controls, and prevents cility; crocedures, such as e applied to an individual cord of incidents and related to infections.  read of Infection ction Control Program resident needs isolation to d of infection, the facility				
	their food, if direct disease. (3) The facility must hands after each of which hand washin professional practi (c) Linens Personnel must ha	st require staff to wash their direct resident contact for ng is indicated by accepted ce.  andle, store, process and as to prevent the spread of	F0441	F441 1.1 Regarding resident 167 wound was assessed by Uni Nurse Manager with no signs symptoms of infection noted 6/20/11.	t s and	5/2011

NAME OF PROVIDER OR SUPPLIER  STANTHONY HOME  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  (X5) (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  1.2 Unit Nurse Managers / designees assessed residents with wounds that require a dressing change for signs and symptoms of infection by 6/23/11 with no deficiencies noted.  1.3 A directed inservice will be held for licensed staff regarding infection control protocols, hand-washing and isolation practices during dressing changes by 7/15/11. Licensed staff orientation program will be		OF CORRECTION	IDENTIFICATION NUMBER:  155214	A. BUILDING	00	COMP.	LETED
(X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  1.2 Unit Nurse Managers / designees assessed residents with wounds that require a dressing change for signs and symptoms of infection by 6/23/11 with no deficiencies noted.  1.3 A directed inservice will be held for licensed staff regarding infection control protocols, hand-washing and isolation practices during dressing changes by 7/15/11. Licensed staff orientation program will be				STREET A	ANCISCAN DRIVE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH DEFICIENCY)  PREFIX TAG  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  1.2 Unit Nurse Managers / designees assessed residents with wounds that require a dressing change for signs and symptoms of infection by 6/23/11 with no deficiencies noted.  1.3 A directed inservice will be held for licensed staff regarding infection control protocols, hand-washing and isolation practices during dressing changes by 7/15/11. Licensed staff orientation program will be			TATEMENT OF DEFICIENCIES		N POINT, IN46307		(V5)
designees assessed residents with wounds that require a dressing change for signs and symptoms of infection by 6/23/11 with no deficiencies noted. 1.3 A directed inservice will be held for licensed staff regarding infection control protocols, hand-washing and isolation practices during dressing changes by 7/15/11. Licensed staff orientation program will be	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETION
content to ensure ongoing sustainable compliance. To monitor staff compliance with directed inservice training (and to allow management to immediately address potential noncompliance), Director of Staff Development / designee will conduct four (4) random supervised dressing changes weekly for six (6) months with different licensed staff (reviewing for compliance with protocols) beginning the week of 7/4/11.  1.4 The DON / designee will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance.  1.5 Systemic changes will be completed by 7/15/11.					designees assessed res with wounds that require dressing change for sign symptoms of infection by with no deficiencies noted 1.3. A directed inservice held for licensed staff resinfection control protoco hand-washing and isolat practices during dressing changes by 7/15/11. Lice staff orientation program updated to reflect inservice content to ensure ongoin sustainable compliance, monitor staff compliance, monitor staff compliance directed inservice training allow management to immediately address por noncompliance), Directed Development / designeer conduct four (4) random supervised dressing chaweekly for six (6) monthed different licensed staff (refor compliance with protobeginning the week of 7.1.4. The DON / designer report audit findings to the Continuous Quality Impression (CQI) Committee month (6) months. The CQI Cowill monitor data presenting any trends, and determing further monitoring is need for compliance.  1.5. Systemic changes completed by 7/15/11.	idents is and if 6/23/11 id. ie will be garding s, ion gensed will be ice ing To with g (and to ential r of Staff will inges s with eviewing pools) id/11. ie will ine ovement y for six ommittee ied for ine if essary will be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155214		(X2) MULTIPLE  A. BUILDING  B. WING	CONSTRUCTION  00	I '	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		STREE 203 F	T ADDRESS, CITY, STATE, ZIP CODE FRANCISCAN DRIVE WN POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG	Based on observatinterview, the fact infection control by licensed staff and isolation prachanges for 2 drefor 2 of 5 resider changes in a sam and #167, LPN # Findings include  1. During an observation of the change of Residing her sacrum, on the change of Residing her sacrum, on the change of t	ation, record review, and cility failed to ensure protocols were practiced related to handwashing ctices during dressing essing changes observed at's with dressing ple of 15. (Residents #24 to 3, LPN #7, and RN #4)	TAG	Nurse Manager with no symptoms of infection no 6/21/11. 2.2 See 1.2 above. 2.3 See 1.3 above. 2.4 See 1.4 above. 2.5 See 1.5 above.		DATE

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 06/21/2011	,
	PROVIDER OR SUPPLIER		203 FR	ADDRESS, CITY, STATE, ZIP CODE ANCISCAN DRIVE N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	D BE COMF	(X5) PLETION ATE
	used a cotton tipe (debridement oin LPN #3 then remapplied new glowhands and applied dressing to the wremoved her glowes, without with the dressing then applied new glowhands. LPN #3 to the resident's group depresson the resident's brid and applied new her hands. LPN stickers for the stickers f	her hands. LPN #3 then ped swab to apply Santyl atment) to the sacral area. hoved her gloves and ves, without washing her d a lightly moistened round. LPN #3 then wes and applied new washing her hands, dated a removed her gloves and ves, without washing her hen applied an ointment groin area with a wooden of the LPN #3 then fastened ef, took her gloves off gloves, without washing #3 then placed the charge applies on the charge slip athroom door, then wes and washed her liew on 06/20/11 at 12:15 dicated she was suppose as between taking the old the putting the new dated 08/09, titled, ges-Wounds", identified Director of Nursing, Remove old dressings, and dispose of Wash hands. Put on				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL	
		155214	A. BUII B. WIN			06/21/2	011
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE ANCISCAN DRIVE N POINT, IN46307	1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	- 11 1	medications/dressings to gloves11. Wash					
	hands"	gioves11. wasii					
	2. During the initial tour on 6/17/11 at						
		PN #6, she indicated the					
	resident had a M						
		ococcus aureus) infection					
		of the right foot. There					
	was an isolation	cart outside of the					
	resident's room in the hallway.						
	Resident #24's record was reviewed on						
	6/20/11 at 8:55 a	.m. Resident #24's					
	diagnoses include	ed, but were not limited					
	to, congestive he	art failure, left above					
	knee amputation,	and atrial fibrillation.					
	A care plan, date	d 06/06/11, indicated,					
	"Acute infectio	n of MRSA to rt (right)					
		it),Maintain contact					
	isolation"						
	A Culture report	for right 3rd toe, dated					
	1 *	"Culture results many					
		ureus (methicillin					
	resistant)"						
	During an observ	vation on 6/21/11 at 10:15					
	~	ered resident #24's room					
	· ·	t's dressing changes. LPN					
		a gown to cover her					
	1 ^	7 washed her hands and					
		ne put a blanket on the					
		he blanket to complete					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE S COMPL	
AND TEAN	or conduction	155214	- 1	LDING		06/21/2	
		100211	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/21/2	
NAME OF I	PROVIDER OR SUPPLIER			1	ANCISCAN DRIVE		
ST ANTH	HONY HOME			1	N POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	JΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		iges. She removed a sock					
		ith betadine from the					
		ight calf and put it on the					
	floor. She removed the soiled dressing						
	from the right calf, washed her hands,						
	applied gloves ar	nd removed the right third					
	toe dressing. There was a yellow						
	substance on the third soiled toe dressing.						
	LPN #7 completed the dressing changes						
	and then stood up and the soiled sock						
	touched LPN #7's pant leg.						
	During an intervi	ew at the time of the					
	observation with	LPN #7, she indicated					
	she should have	wore a gown during the					
	dressing change	due to the resident being					
	on contact isolati	on. She also indicated					
	the soiled sock sl	nould not have been put					
		indicated it should have					
	been put in a bag						
	During an intervi	iew with LPN #6, on					
	~	a.m., she indicated the					
		on contact isolation due					
		the right third toe. She					
		7 should not have put the					
		e floor, she should have					
	put it in a bag.	original mark					
	par ir iii a oag.						
	A facility policy	titled,					
	, , ,	ased Precautions Contact					
		ed 2/09 and revised 6/11,					
	· ·	nt from the Director of					
		ed "Policyresidents					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLE	ETED
		155214	B. WIN			06/21/20	)11
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ANCISCAN DRIVE		
ST ANTH	HONY HOME				N POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	-	DATE
	knownto be inf						
	epidemiologicall	-					
	microorganisms that can be transmitted by						
	direct contact with the resident (hand or						
	skin-to-skin cont	act that occurs when					
	performing resid	ent-care activities that					
	require touching	the resident's dry skin) or					
	indirect contact (	touching) environmental					
	surfaces or reside	ent-care items in the					
	resident's						
	environmentProcedureGOWN1we						
	ar a gown if you anticipate that clothing						
		ntial contact with the					
	resident, environ	mental surfaces, or items					
	· ·	roomLINENS1.					
	Handle, transpor	t, and process used linen					
	1	d, body fluids, secretions,					
		a manner that prevents					
		membrane exposures,					
		clothing, and avoids					
		organisms to other					
		nd environment3.					
		andled in a manner that					
		with the employee's					
	clothing"	with the employees					
	Croming						
	A Professional R	esource titled					
		olation Precautions:					
		mission of Infectious					
	_	care Settings 2007" from					
	1 -	rs of Disease Control),					
	`	· · · · · · · · · · · · · · · · · · ·					
	1	ed, " III.B.1. Contact					
		e application of Contact					
	Precautions for p	patients infected or					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMP: 06/21/2	LETED
	PROVIDER OR SUPPLIER		STREET.	ADDRESS, CITY, STATE, ZIP CODE RANCISCAN DRIVE 'N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	personnel caring Precautions wear all interactions th with the patient of contaminated are environment"  This Federal tag The facility faile	ganism)Healthcare for patients on Contact a gown and gloves for nat may involve contact				

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	1	E SURVEY PLETED 2011
	ROVIDER OR SUPPLIER		203 FR	ADDRESS, CITY, STATE, ZIP COE ANCISCAN DRIVE	DE .	
ST ANTH	IONY HOME		CROW	N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE